APPENDIX A.

TERMS AND DEFINITIONS

Admitted insurer: An insurance company that is licensed (admitted) to conduct business within a given state. If the insurance company experiences financial distress, the regulatory agency can intervene and provide protection to the insured.

Attachment point: The dollar amount of loss where an insurance policy begins to provide coverage.

Activities for Daily Living (ADL): Basic personal activities that include bathing, eating, dressing, mobility, transferring from bed to chair, and using the toilet.

Aging with Dignity Initiative: Governor Davis implemented this Initiative as a policy base for improving long-term care in California. To date, the Administration has committed over $270 million to help elderly people remain at home, or with their families, rather than in nursing homes; dramatically increasing the availability of innovative community-based alternatives to nursing home care; and enhancing the quality of care in California's nursing homes.

Aggregate loss ratio: The total earned premiums for a line of insurance divided by the total claims incurred.

Broker: A marketing specialist who represents buyers of property and liability insurance and who deals with either agents or companies in arranging for the coverage required by the customer.

California Partnership for Long-Term Care: An innovative program of the State of California, DHS, in cooperation with a select number of private insurance companies. These companies have agreed to offer high quality policies that must meet stringent requirements set by the Partnership. The objective is to provide Californians affordable, high quality long-term care insurance that will protect policyholders from having to spend down personal assets, should private long-term benefits be exhausted and Medi-Cal assistance is needed.

Captive insurance company: A company owned solely or in large part by one or more non-insurance entities for the primary purpose of providing insurance coverage to the owner or owners.

Centers for Medicare and Medicaid Services (CMS): A federal agency within the U.S. Department of Health and Human Services. CMS operates the Medicare and Medicaid programs and maintains oversight of the survey and certification of nursing homes and continuing care providers (including home health agencies, intermediate care facilities for the mentally retarded and

hospitals). Prior to 2001 CMS was known at the Health Care Financing Administration (HCFA).

Certified: To receive reimbursement for the care provided to Medi-Cal or Medicare patients, health facilities must gain federal certification. Certification requirements are defined by federal law, regulation, and policy, and occasionally by state law, regulation, or policy, when the federal requirement is that the state requirement be met.

Certified Nursing Assistant (CNA): In California, to gain certification as a nursing assistant, an applicant must complete 160 hours of training, and pass a competency test and background clearance. Under the supervision of a licensed nurse (registered or vocational), a CNA provides basic nursing services to ensure the safety, comfort, personal hygiene, and protection of patients/residents in a licensed long-term or intermediate health care facility. CNAs may not perform any nursing services that require a professional nursing license. CNAs are sometimes referred to as “nursing assistants” or “nurse aides.”

Cession: Amount of the insurance ceded to a reinsurer by the original insuring company in a reinsurance operation.

Change of Ownership (CHOW): A transfer of control of the physical facility and of the legal and financial responsibility to provide care to patients residing in the facility. DHS L&C approval of the new owner’s licensure application is required prior to completing a CHOW transaction (i.e., prior to closing escrow or executing a lease or rental contract).

Citation (State): A monetary penalty that DHS L&C may assess against a nursing home (or other long-term health care facility) when a facility is found to be out of compliance with state licensing requirements. The penalties range from $25,000-$100,000 for violations that are deemed to be the direct cause of death, to $100-$1,000 for violations that have a direct or immediate relationship to the health, safety, or security of the resident. Other state licensing sanctions include: license revocation; temporary suspension of a license (TSO); temporary manager; and receivership.

Civil action: Any action between private parties that is not a crime or a misdemeanor.

Civil Monetary Penalty (CMP)(Federal): A monetary penalty that CMS may impose against a nursing home (or other long-term health care facility) when a facility is found to be out of compliance with federal certification requirements. CMPs can be imposed not only for every day of non-compliance starting with the days of observation during a current survey, but also for every day of past non-compliance, if that past non-compliance can be ascertained. CMPs are only one of the available federal remedies in the certification survey process. Others include: directed plan of correction (POC); directed in-service training; denial of

payments for new admissions; denial of payments for all residents; state monitoring; temporary manager; transfer of residents; closure and transfer; and termination.

Claim: A request for payment of a loss, which may come under the terms of an insurance contract.

Claims frequency: The number of claims projected for a given time period.

Claims-made policy: A liability insurance policy under which coverage applies to claims filed during the policy period.

Claims severity: The measure of the seriousness of a loss, measured by the total dollar amount of paid claims.

Compensatory damages: See **Damages**.

Complaint: When a call or letter received by DHS L&C requires an onsite investigation (see also **reported event)**. The Health Facility Evaluator Supervisor determines whether an onsite investigation is required.

Compulsory insurance: Any form of insurance that is required by law.

Damages: the monetary compensation or indemnity that may be recovered by an individual or entity that has suffered loss. Damages also vary according to the type of civil action pursued. The types of damages pertinent to a discussion of liability insurance for nursing homes include:

- **Compensatory-**Compensation for a plaintiff's documented out-of-pocket expenses that result from injury or damage; for example, loss of earning or medical expenses.

- **General-**Compensation paid for harm for which no specific evidence of financial loss is required because such harm—for example, pain and suffering—is presumed to have occurred from the nature of the event.

- **Exemplary-**Compensation over and above property loss when the act is from malice—for example, wrongful acts, aggravated negligence, but not criminal.

- **Punitive-**Amount of money awarded by a court to "punish" the defendant for acts of gross negligence or outrageous conduct, normally intentional, irrespective of the amount of actual or compensatory damages.[1]

Domain: The state or location of legal "residency" or licensure for the purpose of the insurance operations.

Earned Premium: That potion of a policy's premium payment for which the protection of the policy has already been given. For example, an insurance

company is considered to have earned 75 percent of an annual premium after a period of nine months of an annual term has elapsed.

Facility-reported occurrence (also unusual occurrence**):** A reported event generated by the regulatory requirement that a facility self-report to DHS L&C specified situations that have occurred at the facility. These occurrences may or may not be determined by the Health Facilities Evaluator Supervisor to constitute a **complaint.**

Form 2567: The federal form, also known as the Statement of Deficiency Form, that outlines the survey findings. The 2567 is sent to the nursing home. If there are deficiencies, the facility prepares its **Plan of Correction (POC)** to DHS L&C**.** DHS must approve the POC to complete the process. If a facility does not submit an acceptable POC, DHS (and perhaps the federal CMS) takes appropriate enforcement actions.

General liability insurance: Coverage that pertains, for the most part, to claims arising out of the insured's liability for injuries or damage caused by ownership of property, manufacturing operations, contracting operations, sale or distribution of products, and the operation of machinery, as well as professional services.

"Going bare": An informal description of an uninsured organization or a firm without any type of insurance program or plan for an exposure that is normally insurable.

"Hardening" or Hard market: That part of the insurance sales cycle in which competitive pricing is at a minimum as companies charge the premiums necessary to meet their underwriting losses in order to avoid insolvency and boost capacity; usually associated with a sharp decline in capacity.

Innovative Grants Program: A program that is part of the Aging with Dignity Initiative (provisions included in AB 1731). Facilities that apply and are selected receive innovative grant awards to fund projects that demonstrate methods to improve quality of care and quality of life for nursing home residents.

Joint Underwriting Association (JUA): A device used to provide insurance to those who cannot obtain insurance in the voluntary market. Certain companies (called carriers) issue policies at one rate level and handle claims, but the ultimate costs are borne by all companies writing insurance in that state.

Licensee: The person, persons, firm, partnership, association, organization, company, corporation, business trust, political subdivision of the state, or other governmental agency to whom a license has been issued.

Licensed Vocational Nurse (LVN): In California, a licensed vocational nurse (LVN) is one who has been licensed by the California Board of Vocational and

Psychiatric Technicians. LVNs, under the direction of physicians and registered nurses, provide basic bedside care.

Licensing requirements: To operate a health facility in California, it is necessary to obtain the appropriate license. Licensing requirements are defined by state law, regulation, and policy.

Lloyd's of London: Insurance marketplace where brokers, representing clients with insurable risks, deal with Lloyd's underwriters, who in turn represent investors. The investors are grouped together into syndicates that provide capital to insure the risks.

Long tail: Risk that may have claims notified or settled long after the risk, or policy term, has expired. So that the underwriter can close the account for the year, it is often necessary for an underwriter to arrange reinsurance protection to cover claims that may arise after the account has been closed.

Long-term care (LTC): Long-term care is a set of social, personal care, health, mental health, substance abuse treatment, and protective services required over a sustained time period by a person who has lost or never acquired some degree of physical or cognitive capacity, as measured by a functional and cognitive assessment rather than being tied to a specific diagnosis or linked exclusively to age. (See also Table 1).

Loss ratio: A ratio calculated by dividing claims into premiums. It may be calculated in several different ways, using paid premiums or earned premiums, and using paid claims with or without changes in claim reserves and with or without changes in active reserves.

Loss reserve: The amount set up as the estimated cost of a claim.

Loss reserve development: How the latest estimate of an insurance company's claim obligations compares to an earlier projection.

Malpractice insurance: Coverage for a professional practitioner, such as a doctor or a lawyer, against liability claims resulting from alleged malpractice in the performance of professional services.

Medicare: Federally funded health benefit plan for persons who are aged 65 and qualify for Social Security benefits, and for person who receive Social Security benefits based on disability.

Medicare Payment Advisory Commission (MedPAC): A 17 member independent federal body that advises the U.S. Congress on issues affecting the Medicare Program.

Medicaid (Medi-Cal): Federal program to provide medical care for eligible low-income people. California uses the term Medi-Cal for the program in the state.

Medical malpractice: Improper care or treatment by a physician, hospital, or other provider of health care.

Minimum Data Set (MDS): See **Resident Assessment Instrument (RAI)**.

Non-economic Damages: See **Damages**.

Nursing Home Data Compendium 2000: A document prepared by CMS to present data on all residents in Medicare and Medicaid-certified nursing homes in the United States. It is the first comprehensive aggregation of data at the level of the individual.

Occurrence policy: A liability insurance policy that covers claims arising out of occurrences that take place during the policy period, regardless of when the claim is filed.

Office of Inspector General (OIG): The organization within the federal Department of Health and Human Services with primary authority for protecting the Medicare Program and its beneficiaries. In addition to various enforcement initiatives, OIG also utilizes several programs that rely on collaboration, cooperation, and voluntary compliance on the part of the health care industry to fight health care fraud and abuse.

Omnibus Budget Reconciliation Act (OBRA) '87: Federal legislation that radically changed the requirements for nursing homes. The revised approach utilized outcome-based measurement and focused on whether a nursing home was appropriately assessing its residents, planning a course of action to meet their multiple needs, and taking actions that were responsive to residents' wishes, capabilities, and changing status.

Pain and Suffering: See Damages.

Plan of Correction (POC): The document that responds to the findings included on Form 2567. DHS L&C conducts on-site inspections or **surveys** of facilities on a periodic basis and in response to complaints filed by the public. At the completion of the survey, staff prepares a report to the facility that may list violations of various laws and regulation. The facility must then prepare a POC addressing how each deficiency will be corrected. The POC must be approved by DHS L&C to avoid enforcement remedies.

Pooling arrangement: An agreement where a group opts to share losses and expenses among members of the pool, typically with each paying a predetermined ratio.

Professional Liability: Coverage for "errors or omissions" found in the conduct of performing professional services. Also see **Malpractice Insurance**.

Prospective Payment System: Payment rates are established before the care is delivered and costs are incurred. Providers, therefore, have an incentive to avoid unnecessary costs.

Purchasing Groups (PG): An organization that puchases liability insurance on a group basis from an insurance company or a **Risk Retention Group (RRG)** for its members. (Also see Table 3, page 24).

Punitive damages: See **Damages.**

Quality Awards Program: A program that is part of the Aging with Dignity Initiative (provisions included in AB 1731). Awards go to facilities whose performance histories indicate that they provide exemplary care to residents. Facilities serving a high proportion of Medicaid residents qualify for financial awards. The statute authorizing these quality awards requires that any monetary awards be distributed as bonuses to staff of the facility.

Qui-Tam*:* ("who sues on behalf of the king as well as for himself") A provision of the Federal Civil False Claims Act that allows a private citizen to file a suit in the name of the U.S. Government charging fraud by government contractors and other entities who receive or use government funds, and share in any money recovered.[2]

Registered Nurse (RN): In California, a registered nurse (RN) is one who is licensed through the California Board of Registered Nursing. In addition to supervising licensed vocational nurses and nursing aides, RNs have the broadest scope of practice among nursing staff.

Reinsurance/Reinsurer: The purchase of insurance by an insurance company from another insurance company (reinsurer) to provide it protection against large losses on cases it has already insured.

Reported event: Any concern or alleged violation against a health facility or provider under the jurisdiction of DHS L&C reported from any source, including **facility-reported or unusual occurrences** (See Complaint). Initially when a call or letter is received, it is a reported event. The Health Facilities Evaluator Supervisor determines if the reported event requires an onsite investigation.

Reserve: An amount representing liabilities kept by an insurer to provide for future commitments under policies outstanding. (2) An amount allocated for a special purpose. Note that a reserve is usually a liability and not an extra fund.

Residential Care for the Elderly (RCFE): In California, a facility licensed by the Department of Social Services that provides care, supervision and assistance

with activities of daily living, such as bathing and grooming. RCFEs may also provide incidental medical services under special care plans. The facility provides services to persons 60 years of age and over and persons under 60 with compatible needs. RCFEs may also be known as assisted living facilities, retirement homes, and board and care homes. The facilities can range in size from 6 beds or less to over 100 beds.

Residual market: A source of insurance available to applicants who are unable to obtain insurance through ordinary methods in the voluntary market.

Resident Assessment Instrument: was developed by the federal government to help facility staff to gather definitive information to be addressed in an individualized care plan. The RAI consists of three elements:

- **Minimum Data Set (MDS)** – core set of screening, clinical and functional status elements that form the foundation of the ocmprehensive assessment of all residents.
- **Resident Assessment Protocols (RAPs)** – structured problem-oriented frameworks for organizing MDS information.
- **Utilization Guidelines** – Instructions concerning when and how to use the RAI.

Retention: The net amount of risk retained by an insurance company for its own account or that of specified others, and not reinsured.

Risk management: Procedures to minimize the adverse effect of a possible financial loss by identifying potential sources of loss, measuring the financial consequences of a loss occurring, and using controls to minimize actual losses or their financial consequences.

Risk Retention Group (RRG): An alternative form of insurance in which members of a similar profession or business band together to self insure their risks. (Also see Table 3, page 24).

Self-insured: A corporation or entity establishes reserves to pay for potential claims, rather than purchasing outside. The claims are internally managed by the organization.

Self-pay: The responsibility for payment of nursing home costs is that of the resident or her or his authorized representative.

Short-tail: Business on which claims generally arise and are settled quickly.

Skilled nursing facility (SNF): The legal term for a health facility that provides continuous skilled nursing care and supportive care to those whose primary health care need is the availability of skilled nursing care on an extended basis.

A SNF can be freestanding, meaning the facility is licensed as a stand-alone facility. There are also distinct-part SNFs, which function as a wing or unit within another kind of licensed health facility, most commonly, acute-care hospitals. The term "nursing home" is sometimes used interchangeably for SNF. (See also Table 1, page 4).

Skilled Nursing Facility Financial Solvency Advisory Board (SNFFSAB): Part of the Aging with Dignity Initiative (provisions in AB 1731). DHS will convene a SNF Financial Solvency Advisory Board, consisting of eight members with expertise in the fields of health economics, accountancy, consumer advocacy, employee organizations, and health care management. The Board will recommend appropriate financial standards for facilities to meet to qualify for a license, and methods to monitor facility financial status, in order to promote early intervention when facilities begin to face financial problems that could lead to disruptions in care.

Soft market: That part of the insurance sales cycle in which competition is at a maximum as insurance companies use their excess capacity to sell more policies at lower prices.

State Citation: See **Citation**.

Statement of Deficiency Form, or Form 2567: A form utilized to outline the survey or complaint findings. The Form 2567 is sent to the health facility. If there are deficiencies, the facility prepares its POC which the State must approve. Survey staff conduct a follow-up review to verify that corrections have been made. If a facility does not submit an acceptable POC, DHS takes appropriate enforcement actions. If DHS determines that deficiencies identified on a survey warrant a State Citation, a separate Citation document is written and financial penalties are assessed. The facility is also required to submit an acceptable POC on a Form 2567 for the compliance issue identified in the Citation.

Surplus lines: (1) A risk or a part of a risk for which there is no normal insurance market available. (2) Insurance written by non-admitted insurance companies.

Surveys: The California Department of Health Services' Licensing and Certification Program determines the compliance of health facilities with the applicable licensing and certification requirements through unannounced team inspections called "surveys." There are several kinds of surveys, including initial certification or licensure surveys that are required before a facility can gain either a license to operate or certification for reimbursement; regular surveys conducted on a periodic basis to evaluate compliance; and surveys conducted in response to a complaint investigation that finds cause for closer examination of a facility's practices. During the survey process, the survey team examines facility records; conducts staff and patient interviews; and makes careful observations of patient care, staff and management activities and interaction, and facility operations.

Tail coverage: Coverage that can be purchased after the expiration of a claims-made liability policy that extends for a period of time, with or without limit, the right to report events that occurred before the policy was terminated.

Umbrella liability: Insures losses in excess of amounts covered by other liability insurance policies; also protects the insured in many situations not covered by the usual liability policies.

Underwriter: (1) A company that receives the premiums and accepts responsibility for the fulfillment of the policy contract; (2) The company employee who decides whether or not the company should assume a particular risk; (3) The agent who sells the insurance policy.

Underwrites/Underwriting: The process of selecting risks for insurance and determining in what amounts and on what terms the insurance company will accept the risk.

Underwriting profit or loss: The amount of money that an insurance company gains or loses as a result of its insurance operations. It excludes investment transactions and federal income taxes.

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[1] Ahrens, op. cit., p. 86.
[2] The Qui Tam Information Center, The Bauman & Rasor Group, Inc., www.quitam.com.
Rupp's Insurance Glossary, www.nils.com/rupps/
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